PM FORM 3.14.1
CERTIFICATE OF NEED (CON)
(Level I Facilities)
Fax to: (602) 364-4749

☐ Inpatient Psychiatric Services ☐ C/A Residential Treatment Center

Date and Time of Con:
Client Name:
AHCCCS #:
Client ID/D.O.B:
Case Manager:

Address:
Social Security #
Home Telephone #:
CM Telephone #:

1. DSM-IV Diagnostic Codes Axis I _____ Axis II_____ Axis III _____ Axis IV _____ Axis V _____

2. Reason for Admission-(Current Symptoms, Mental Status, Specific Behavior and Current Medications):

Mental Status:

Oriented: ____ (Time, Person, Place, Situation): Level of alertness ☐ Partial ☐ Full

Speech ☐ Normal ☐ Abnormal: Specify_____ Sleeping ☐ Normal ☐ Abnormal: Specify_____

Eating ☐ Normal ☐ Abnormal: Specify_____

Mood ☐ Normal ☐ Depressed ☐ Elevated ☐ Agitated: Specify_____

Affect ☐ Normal ☐ Constricted ☐ Blunted ☐ Other: Specify_____ Mannerisms ☐ Normal ☐ Abnormal: Specify_____

Behavior ☐ Actively participates ☐ Refuses activities or treatment ☐ Cooperative ☐ Uncooperative

Delusions ☐ None ☐ Active: Specify_____

Hallucinations ☐ None ☐ Auditory ☐ Visual ☐ Olfactory

Thought Process ☐ Normal/Logical ☐ Abnormal: Specify_____

Associations ☐ Normal ☐ Abnormal: Specify_____ Stream ☐ Normal ☐ Abnormal: Specify_____

Judgment ☐ Good ☐ Impaired/Limited ☐ Fair ☐ Poor ☐ Other:_____

Insight ☐ Good ☐ Impaired/limited ☐ Fair ☐ Poor ☐ Other:_____

DTS Behaviors: ☐ Recent: specify dates _____ ☐ Potential /At Risk for ☐ None

DTO Behaviors: ☐ Recent: specify dates _____ ☐ Potential /At Risk for ☐ None

3. Explain why ambulatory care resources available in the community do not meet the treatment needs of the client. If services were provided in the community, why did the services not meet the needs of the client?

4. Identify the Level I services that can reasonably be expected to improve the client's condition or prevent further regression, so that services will no longer be needed. Include anticipated length of stay and discharge after care plan.

I am aware of the client's condition and have been provided sufficient information to determine this level of care is appropriate.

Physicians Signature _____ Print Name _____

Dated: ____/____/____

Proposed Placement:

*Provider Name:
*Requested Date of Admission:
*Requested Service Dates: From: To: Discharge:

The CON must be completed 1) Prior to admission or at the time of admission 2) In an emergency Admission, the CON must be completed within 24 hours 3) If an individual applies for Medicaid Assistance while in the hospital, the CON must be completed before Medicaid funding is authorized. The CON needs to be completed and faxed to the T/RBHA.

Revision Date: August 29, 2002